

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003984

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

717

STATE FILE NUMBER

FILED JAN 31 1963

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN ST. LOUIS, MISSOURI

Length of stay in 1b

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo

b. COUNTY Scott

Inside Limits

Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION BARNES HOSPITAL

Inside Limits

Yes ☐ No ☐

c. CITY OR TOWN Morley

d. STREET ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED  
(Type or print)

First

WILLIAM

Middle

CLINCY

Last

PORTER

## 4. DATE OF DEATH

Month

JAN.

Day

21

Year

1963

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

## 8. DATE OF BIRTH

4-19-1887

## 9. AGE (last birthday)

75

## IF UNDER 1 YEAR

Months Days Hours Min.

## IF UNDER 24 HR

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

## 10b. KIND OF BUSINESS OR INDUSTRY

Restaurant

## 11. BIRTHPLACE (City and state or country)

Johnson County, Ill.

## 12. CITIZEN OF WHAT COUNTRY

U.S.A.

## 13a. FATHER'S NAME

James Porter

## 13b. MOTHER'S MAIDEN NAME

Martha Foster

## 14. NAME OF HUSBAND OR WIFE

Floy

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Hess Porter

## Address

Illmo Mo

18. CAUSE OF DEATH (Enter only one cause per line)  
PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

SEPTICEMIA

INTERVAL BETWEEN ONSET AND DEATH  
DAYS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

## DUE TO (b)

UREMIA

593x

MONS.

## DUE TO (c)

RENAL DISEASE, ETIOLOGY UNKNOWN

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

## PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?  
YES ☒ NO ☐

## 20a. ACCIDENT

☐

## SUICIDE

☐

## HOMICIDE

☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

## 20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

## 21. I attended the deceased from 1/8/63 to 1/21/63 and last saw her him alive on 1/21/63

Death occurred at 11:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

C. D. Vermillion, M.D.

M.D.

## 22b. ADDRESS

BARNES HOSPITAL

## 22c. DATE SIGNED

1/23/63

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

## 23b. DATE

1-24-63

## 23c. NAME OF CEMETERY OR CREMATORY

Old Morley

## 23d. LOCATION (City, town, or county)

Morley Mo

## (State)

## 24. FUNERAL DIRECTOR

## ADDRESS

Bisplinghoff Funeral Home

ILLINO

## 25. DATE RECD. BY LOCAL REG.

JAN 23 1963

## 26. REGISTRAR'S SIGNATURE

Road Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

VS 300  
Rev. 4/59

1

2100068

3

4

0

5

1

6

7

1

8

1

9

10

11

1252-0

13

52

MAR 13 1963

STATEMENT BY LICENSED EMBALMER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James L. Crosson

Licensed Embalmer No. 5168

P. O. Address Millerville, Ill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.